

# St. Bartholomew's Hospital



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### St. Bartholomew's Hospital Journal,

FEBRUARY, 1900.

"Æquam memento rebus in arduis  
Servare mentem."—Horace, Book ii, Ode iii.

**S**IR MICHAEL FOSTER'S return to Parliament as representative of the University of London is a matter for congratulation to all concerned. A good deal has been said about the undesirability of sending a man to the House of Commons more on account of his eminence as a scientist than as possessing any claims to be called a politician. But the representative of a University should at least be eminent as something,—this every one must admit. And from all that we see it would scarcely seem to bode ill for English legislature if our Parliament contained fewer politicians and more eminent men. At least, we should ourselves be quite Radical enough not to fear the consequences of such an experiment being made. Moreover, the question as to whether Sir Michael's attitude is "safe" towards the War or towards Home Rule

is of much less importance, in the light of his constituency, than the influence he will wield on matters of education; and most will agree that this is likely to be at least as great as that of either of his less eminent opponents.

And even at the lowest estimation, outside any consideration of eminence at all, Sir Michael Foster has rendered a public service of no mean sort by saving us from the calamity of seeing an anti-vaccinator sent to Westminster as the representative of a University who is justly proud of her medical education, and reasonably jealous of her medical reputation. The public is sufficiently awake to the weakness of our system of party government to know that the "conscience clause" was only a passing shibboleth to catch votes. But if the University of London returned to Parliament a medical man who signed the Minority Report the laity might reasonably doubt the practical unanimity of the profession upon the question of vaccination.

It was not to be supposed that the anti-vivisectionists would let slip the opportunity of venting their spleen upon so distinguished a physiologist as Sir Michael Foster, and their manifesto against his candidature came duly to hand as expected. The circular began by "respectfully offering for the consideration of the members of Convocation certain information concerning the labours of this distinguished gentleman." These labours seem, according to the paragraphs that follow, to have been chiefly the joint-editorship of a book resembling a "cookery book of receipts, with the difference that the flesh which the students are instructed to cut, saw, and pick to pieces, is to be still living and quivering," and the leadership in the "vivisectional work for which Cambridge has obtained a painful notoriety." Were the members of Convocation as ignorant of Sir Michael Foster's "labours" as the compilers of the letter in question, they might have thought, from the descriptions given of it, that his life work was hardly based upon the most approved ethical standard. But the circular hastens to add that "with his moral opinions and conduct we have no concern, and believe them to be highly correct." Which opinion, despite the inconsistency involved, was of course most timely.

## A Clinical Lecture on a Case of Crossed Hemiplegia with Hemianæsthesia.

By DR. GEE.

(Reported by T. J. HORDER.)

**G**ENTLEMEN,—By hemiplegia is meant paralysis of movements on one side of the body. But hemiplegia is never universal, but particular, only some of the movements being paralysed. Therefore there is a large variety of hemiplegias, unlike each other, according to the different movements that are paralysed. Now the ordinary form, the standard of hemiplegia because the most frequent form, is the following :—The highest movements paralysed are those of the lowest part of the face, *i. e.* movements of mouth, nose, and cheek of one side, not of the eye or forehead; then movements of the tongue, so that the muscles on the unaffected side push it over to the affected side; all the movements of the arm and of the leg. This is the ordinary form of hemiplegia, and when you get this form you may be quite certain the disease causing it is somewhere in the pyramidal tract between the corpus striatum and the pons Varolii. The most usual situation is the corpus striatum, seldom the pons, and still more seldom the crus cerebri. When such a hemiplegia affects the right side, and if it be associated with aphasia, you may be tolerably certain that the disease is obstruction of the left cerebral artery supplying the corpus striatum and the cortex with its underlying part of the brain. This is nearly always the cause, and is due to arteritis or embolus.

Before reading you the notes of this case I will say a few words about two conditions which it is necessary for you to understand before you can properly enter into it.

(1) *Crossed hemiplegia*, that is ordinary hemiplegia associated with paralysis of one of the cranial nerves on the other side; for instance, ordinary hemiplegia on one side, and paralysis of the seventh nerve on the other side. Here *all* the muscles supplied by the seventh nerve are paralysed. A crossed paralysis may involve almost any of the cranial nerves,—the third (not common) in disease of the crus cerebri, the fourth and sixth again (but also uncommon), the fifth in disease of the pons, and the seventh also.

(2) *Hemianæsthesia* is sometimes associated with hemiplegia, but seldom, and this hemianæsthesia associated with hemiplegia is either due to structural disease of the brain—organic, visible disease,—or is hysterical. Hemianæsthesia due to structural disease of the brain is usually associated with hemipopia. In hysterical hemianæsthesia the sight *is* affected, but so far as I have seen in a different way: not hemipopia—half-blindness of the field of vision—but an amblyopia of the eye on the same side as the hemianæsthesia. If the hemianæsthesia is on the right side,

sensibility is lost in the leg, arm, trunk, face, scalp of that side, and vision of the right eye, hearing of the right ear, taste and smell on that side are bad. If the hemianæsthesia be due to structural disease it is not the sight of the right eye only that is bad, but the loss of vision—the hemipopia—is for both eyes. I gave a lecture some time ago on a case of the former kind of hemianæsthesia: a man who had left hemiplegia and anæsthesia exactly limited by the middle line, involving touch, pain, heat, and cold; smell defective on the left side; sight, marked contraction of the field of vision for the left eye; taste also defective; hearing, the test discounted on account of old ear disease. Though the patient was a man I considered him to be hysterical, and this was proved by the fact that he soon left the hospital quite well, except that the field of vision was still contracted.

You are now prepared to enter into the points of this case. The patient, a married woman aged 38 years, was admitted to Hope Ward for paralysis and inability to speak.

She had had much mental trouble recently, having nursed a daughter who died fourteen days previous to patient's admission. Since that she had eaten little, and had taken much brandy. On February 5th she went out walking with a friend; she told her friend that she "felt bad." Ten minutes later the present attack commenced. She felt as if she were going to be choked, and as if her jaw would be locked. Then her friend noticed that the patient's left arm and leg and the left side of the mouth were "drawn stiff." She did not fall, but with assistance entered the house. She did not lose consciousness. Her left arm and leg were found helpless, and she could not speak. An hour later she said with some difficulty a few words to her friend; she also spoke in the evening. On February 6th she could not speak. Since the attack she has been able to swallow liquid food, and she has consciously passed urine and feces into the bed.

As regards her previous history, we learnt that she had been accustomed to the abuse of alcohol for many years, and especially lately. She had suffered from vomiting for many months, with slight hæmatemesis occasionally in the morning; all this doubtless due to the drink. The husband described several "drunken fits."

The condition on admission was as follows: Stout, muscular, healthy-looking woman; temp. 98.6°; pulse 96, regular, small, and soft; arteries not thickened; respirations 25, regular, somewhat laboured, the left ala nasi working more strongly than the right (*i. e.* the right was paralysed). She lies on her back with legs extended; she is fully conscious and intelligent, but is unable to utter any word. She answers questions readily by movements of the head. She can read, and can execute a written order. When told to write she wrote with a trembling hand, "I want to speak." (We have a specimen of her

handwriting, which shows nothing in particular.) Face :— The cheeks are flushed ; the naso-malar and labial folds are obliterated on the right side ; they are highly marked on the left side ; the mouth is distinctly drawn over to the left side ; the upper part of the face is natural. When told to frown she moves the muscles naturally and equally on the two sides ; she can raise the brows and close the lids with equal force on the two sides. (No paralysis, you see, of the upper part of the face.)

The masseter and temporal muscles are equally forcible on both sides. The tongue is large and covered with white fur ; it can be protruded for a short distance and directly forwards. (So the paralysis was restricted to the lower part of the face on the right side.) Eyes :—pupils, natural ; no deviation of eyes ; no nystagmus ; visual field, estimated with two fingers, natural in the right eye, and without doubt much contracted generally in the left eye ; discs, natural. Chest and abdomen :—nothing abnormal. Limbs :—no wasting. Right arm : movements natural but tremulous. Left arm : helpless ; a faint muscular contraction of the flexor muscles is the utmost that can be obtained. Sometimes there is distinct rigidity of the elbow and wrist, at other times there is none. Right leg : in every way natural. Left leg : lies helpless in an everted and abducted position with foot-drop. The knee is held rigidly extended when the leg is raised. Knee-jerks brisk and equal on both sides. (Let us recall what we have arrived at : the lower part of the right side of the face, the left arm and leg, were paralysed ; contraction of the field of vision of the left eye.) Sensation : on the right side of the body this is natural, but on the upper part of the left side of the face there is deficient sensation of touch and pain, and complete anæsthesia and analgesia on the left side of the face, the left side of the body, and the left limbs. (We have to add, therefore, hemianæsthesia on the left side, that is on the same side as the paralysis of the arm and leg.)

In this state I saw her, and then I reflected thus :—She has paralysis of left arm and left leg, and she is aphasic. Now aphasia very seldom accompanies left hemiplegia ; it was a great anomaly at any rate. Then, examining more carefully, we found a greater anomaly ; the arm and leg were paralysed on the left side, and the face on the other side. And the question arose, Is this a crossed hemiplegia ? The answer was soon ready : No, because the paralysis did not affect *all* the muscles supplied by the seventh nerve ; it was not a paralysis affecting the whole nerve, but a branch only. There were thus two very great anomalies, and I felt quite convinced it was a purely hysterical, functional disorder. If I had known what was afterwards found, I could have added this third anomaly to the others, that the hemianæsthesia was of the character of hysterical hemianæsthesia, *i. e.* *no* hemiopia, but amblyopia of the eye on the side of the anæsthesia. Thus we had three reasons for believing the patient to be

hysterical. There were other points of less importance confirming this view. (a) The aphasia varied ; for sometimes she could talk, and sometimes she could not. This was not like ordinary aphasia. (b) There was variable rigidity of the limbs, and in this very early stage of the hemiplegia.

To continue the notes of the case :—

The urine was natural. The bowels acted naturally. Patient vomited after taking some milk, and complained of much flatulence. Later she was found sobbing, and when asked to write down the cause she wrote the name of her recently dead daughter. After many efforts at articulation she distinctly said the word "dead." Two hours afterwards she said the word "pain." Later she said other words. (So the aphasia soon passed off.) Next day she could talk without much difficulty. The hemianæsthesia disappeared. The left arm and leg could be moved slightly, and objects could be feebly grasped with the left hand. Next day the left visual field was natural, the movements of the left limbs were weak, but the facial movements were natural. The day after that the patient insisted on going out (which we allowed, because she was quite well).

So the course of the disease showed that it could not be due to structural change, although there was a close similarity to what we get as the result of this. What with the illness of the daughter, her death, and flying under these circumstances to drink,—all these tended to provoke hysteria, and particularly in a woman, though hysteria is not peculiar to women.

Now hysterical hemiplegia, for some reason or another, is much commoner on the left side. I looked up a text-book which probably many of you use, and I found two statements with which I entirely disagree.

(a) That the face is not affected in hysterical hemiplegia. But here it was ; and the statement is not true. You may have the face affected.

(β) That in hysterical hemianæsthesia you get hemiopia. Now I do not think you do, or rather, if you do, I do not know of it. The affection of sight I have seen has always been amblyopia on the same side as the hemianæsthesia.

This was an interesting case for several reasons. If you were called to a case of a woman who had lost her speech, and had become paralysed, you would be asked for your opinion. My opinion was very favourable : "I do not think there is any disease of the brain, and the patient will probably get quite well." Again, the case raises many points connected with hemiplegia which cannot be understood without carefully studying such cases, and which are the only grounds upon which you can base a reasonable diagnosis or prognosis.



## The Portland Hospital.



WE have received the following letter from Mr. Bowlby, containing a further account of the work of the Portland Hospital:

RONDEBOSCH CAMP; February 5th, 1900.

DEAR SIR,—Since I wrote you my first letter the Portland Hospital has had many fresh arrivals, and not a few of our first patients are back at the front again, none the worse for their injuries.

I have now had the opportunity of seeing a great many cases of gunshot wound here and at the three large military hospitals in this neighbourhood; and, as I can now write with more personal knowledge than I could do previously, I will tell you what general conclusions can be safely drawn at this stage.

In the first place, it may be stated that the large majority of the wounds are caused by the Mauser bullet, which has a diameter of .297 inch, and is a leaden bullet weighing about half an ounce, with a mantle or envelope of hard nickel steel, enclosing the lead and preventing it spreading on impact. It is about as thick as a common lead pencil.

In some cartridges the Mauser bullet is composed of soft uncovered lead, which "spreads" on impact, and causes extensive laceration of soft tissues and smashing of bones. These bullets are manufactured for sporting purposes, and are used to stop big game.

The other rifle, used by a considerable number of the Free Staters, is the Martini-Henry, which has a much larger calibre than the Mauser, and throws a bullet measuring .45 inch, composed of hardened lead, without any mantle to enclose it, and weighing about one ounce.

The very large majority of the wounds are caused by Mauser or Martini-Henry bullets, but those caused by the soft or so-called "sporting Mauser" are quite rare.

The wound of entry of the common Mauser bullet is a very small round aperture, with edges which are commonly rounded and dark brown or black. The exit wound is usually exactly the same size as the entrance wound, and the two cannot be distinguished from each other.

The wound caused by the Martini-Henry bullet is at least twice the size of that caused by the Mauser, and is less regularly circular. Its exit wound is usually larger than that of entrance. The wounds caused by these bullets can almost always be distinguished from those caused by the ordinary Mauser.

*Bullet wounds of soft tissues.*—In cases where the wound does not involve the viscera or the large vessels, and so is not rapidly fatal, the natural course is that a copious blood-stained discharge exudes from both openings for a week or ten days, the amount of fluid being proportionate to the bulk of the tissues traversed by the bullet. A small slough

separates, and the wound then rapidly dries up and heals, the scar caused by the Mauser bullet being often so minute that it cannot readily be perceived. The amount of the discharge and the length of time occupied in healing are both greater in the case of the Martini-Henry than in that of the Mauser.

It is so much the exception for these wounds to suppurate that we have not had a single case in the Portland Hospital, and in the other hospitals it is just as exceptional. The explanation is not very apparent, but it is no doubt in large part due to the excellent arrangements for dressing wounds on the field. Each man has sewn to the inside of his tunic an antiseptic dressing, and this is often applied within a few minutes of the receipt of the injury by an officer or orderly of the Royal Army Medical Corps, or else by one of the comrades of the wounded man.

It rather upsets preconceived ideas of the necessity of preparing the skin before operation to find that a wound inflicted on a man begrimed with dust and sweat and powder heals without the least suppuration or pyrexia if properly dressed at the time of injury, and if the soaked dressings are often enough changed. It is quite possible that the very dry pure air of the districts where these wounds are mostly inflicted may account for some of this immunity from sepsis, but this is impossible to affirm or deny at present.

*Wounds involving bones.*—The Mauser bullet inflicts the minimum of injury on a long bone. In most cases it causes a transverse or slightly oblique fracture at the point struck, and does not cause extensive comminution. The shorter the range the more is the bone splintered as a rule; but there are numerous exceptions. Much more rarely the compact tissue of the shaft of a long bone is simply drilled through without solution of continuity, and though this is frequently spoken of as if it were a common occurrence, I think it is quite undoubted that such an injury is really rare, although perforation of cancellous tissue is not very uncommon. Wounds complicated by fractures usually heal with no more trouble than simple flesh wounds if they are properly dressed and splinted.

The Martini-Henry bullet is liable to cause much more comminution of bone, and it probably never simply perforates a bone.

The soft-nosed bullet of the sporting Mauser, and the various bullets which, like the "Dum-dum," are concave at the extremity, or have a tunnel bored down the centre, all "spread" or "mushroom" on meeting with any resistance, so that although their wound of entry may be small, they plough large cavities in the parts through which they pass, and if they strike a bone they smash it into many fragments, both large splinters and minute particles being driven into the neighbouring tissues. The wound of exit caused by such a bullet may be as large as the palm of the hand, and may either be concave, or may be occupied by a mass of muscle and fascia blown out and extruded by the

expansive force of the projectile, the fragments of bone being driven into the parts around by the impetus given to them by the expanding bullet. Wounds such as these look as if they had been caused by a real explosion.

*Wounds of joints.*—Nothing is more surprising than the way in which joints may be perforated without serious consequences if the bones be not comminuted. We have now in hospital three cases illustrating this.

(a) Ankle-joint. Entry wound just below the internal malleolus, with exit through the fibula an inch above the articulation, the bullet passing directly through the joint, which is perfectly moveable within three weeks of the injury, the patient walking with hardly any limp.

(b) Wrist-joint. Entry wound over posterior surface of ulna, and exit wound in mid-palmar aspect, an inch below the articulation, the bullet traversing the interarticular cartilage. The wound healed in a few days, and the wrist is moveable and quite useful.

(c) Shoulder-joint. Bullet wound passing directly through the joint from before backwards. The joint was so perfectly recovered in three weeks that we sent the man back to his work with a battery of artillery.

All these injuries were caused by Mauser bullets, and I think that none of them could have been caused by the Martini-Henry. No doubt when the articular surfaces are comminuted movement must be impaired, but even when the bones are fractured the opening of the joint itself causes but little trouble in most cases. It depends almost entirely on whether the wound remains aseptic.

There have been many interesting cases of injuries of nerves and vessels, but I will write of these on another occasion.

We have had plenty of work lately, and as we are expecting a convoy of sick this afternoon I think that for to-night we shall be already over-full with about 106 cases; but some of our patients leave to-morrow, so that we shall not be too crowded. There have been plenty of medical as well as of surgical cases, and Dr. Tooth had intended writing to you an account of them, but he has been asked to go and see some of the patients in hospital at the Modder River, so that his letter must be postponed, although when it does arrive it will be all the more interesting.

Like all the other hospitals in Cape Colony, we are waiting for the advance of our troops into the Free State before we can be moved up; but I think it is very possible that my next letter may be from the enemy's country—I hope Bloemfontein,—for that would mean both a change of scene for us and a victorious advance for our troops.

Meantime there is much of interest here in addition to hospital work. The constant arrival of fresh troops, the accounts we get from officers and men from the front, and the opportunities of discussing Cape Colony affairs with men who live here are all attractive; added to which we have visits from very many people who are much inter-

ested in our camp and its equipment. Of our numerous visitors I will only mention two, namely, Lord Roberts and Sir Alfred Milner, the latter of whom has been out here on two occasions, in spite of the many calls on his time.

Of the war itself I can give you no more news than you have at home. Of Natal we hear less than you do, whilst we are all very anxious about Ladysmith. It is hoped that an early advance will be made here, for General Kitchener has been arranging the transport so as to make our movements independent of the railways, and when that is done we shall be able to choose our own line of march, and no longer leave it to the Boers to decide at what point on the railway they can most effectually stop us; for our progress by rail has allowed them hitherto in every case to choose and prepare the battle-field, and to mark all the ranges and prepare a line of retreat. I trust this is now a thing of the past. As to the Boer losses, it is impossible to get at the truth, but there is no doubt that there is much enteric fever in their lines as well as dysentery, both at the Modder River and round Ladysmith.

As for ourselves, we are all very well, and our camp continues to prove most sanitary. Both Watson and Jameson, who were recently on our Junior Staff, are at No. 1 Hospital, Wynberg, and high in the esteem of the Army Medical head-quarters; whilst two other old Bart.'s men, Molteno and Wright, are in private practice at the same place. I suppose there are not many places in the world where there is not some representative of our School.

Yours always truly,

ANTHONY A. BOWLBY.

### Certain Cases in Toxicology.

*A Paper read before the Abernethian Society,  
November 9th, 1899.*

By F. WOMACK, M.B., B.Sc.Lond.



TOXICOLOGY, as a subject of medical study, is one of subsidiary importance, and rightly so, as its practice involves a degree of technical acquaintance with chemical processes which can by no means be fairly expected of the general medical practitioner, who has only limited opportunity either during his hospital or later career of coming into contact with cases of poisoning. But though this is the case, it can hardly be entirely omitted from the curriculum of medical study. Every practitioner is likely at some time to meet with cases of opium poisoning, of lead poisoning, or of carbolic acid, and these and a few others may be advantageously studied, particularly from the point of view of treatment.

Before proceeding to speak of my own experience—now extending officially over some five years—of poisoning cases occurring within the London area, it will prove, I think, not uninteresting to refer to forms of poisoning employed at earlier periods than the present.

The poison which was probably first known, or of which we have the earliest record, is *hydrocyanic acid*. This poison, it would appear, was used officially by the Egyptians. There is a papyrus at the Louvre in which occurs the sentence, "Utter not the name of IAO, under penalty of the peach," which implies that a publication of certain secrets of the priesthood was punished by compelling the

accused to drink a distillate made from leaves or kernels of the peach.

The employment of some preparation containing prussic acid was continued during the earlier period of the Roman empire, if we may infer this from the sudden character of the death in certain cases recorded of accusation of treason.

More than 2000 years ago two treatises were written by Nicander (204 to 138 B.C.), one on snake poison, and the other giving an account of various poisons of vegetable origin, amongst which are named aconite (so called from the town Akon in Heraclea), opium, hemlock, colchicum, henbane, and certain fungi.

Some century and a half later Dioscorides (40—90 A.D.) wrote on these and other poisons, amongst which latter were elaterium, a preparation known as mandragora (probably from different species of *Solanum*), cantharides, sulphate of copper, and compounds of mercury, lead, and arsenic. Hellebore, black and white, were known and used by the Romans, who probably poisoned their arrows with a preparation from these plants. The natives of India were also familiar with many vegetable poisons, and it has been suggested that the immolation of the Hindoo widow on the funeral pyre of her husband was a religious rite initially ordered to put a stop to the practice of husband poisoning formerly so rife amongst that race. It would appear that this method of punishment was successful in stamping out the practice.

But it was in Europe during the Middle Ages that poisoning was raised to absolutely a fine art. Its practice was certainly prevalent for fully three centuries, and arsenic seems to have been the favourite poison for administration. Nor is this surprising when one collects the characters of this substance (arsenious oxide), its innocent appearance, its nearly perfect tastelessness, its consequent ease of administration in food, its very small fatal dose, and the then impossibility of detection. Besides this the symptoms following its imbibition are such as are met with in many common illnesses—vomiting, diarrhoea, cold sweating.

Among the many instances that might be cited, perhaps the most striking is that of Charles the Bad, King of Navarre. This worthy gave a written commission, now extant and kept at Chartres, to a minstrel named Woudretton to poison Charles VI and the Duke of Valois (the King's brother), and also his three uncles, the Dukes of Berry, Bourbon, and Burgundy—of which the following is an extract:\*

"Tu vas à Paris, tu porras faire grand service se tu veulx. Se faire ce que je te diroy, je te feroy tout aisé et moult de bien. Tu feras ainsi: il est une chose qui se appelle arsenic sublimat. Si un homme en mangeoit aussi gros qu'un poix, jamais ne vivroit. Tu en trouveras à Pampelune, à Bordeaux, à Bayonne, et par toutes les bonnes villes ou tu passeras, es hotel des apothicaires. Prends dela et fais en de la poudre et quand tu seras dans la maison du roi, du comte de Valois son frere, des ducs de Berry, Bourgoigne et Bourbon, tray toi près de la cuisine, du dressouer, de la bonteillerie ou de quelques autres lieux où tu verras mieulx ton point, et de cette poudre mets es potages, viandes ou vins, au cas que tu pourras faire à la seureté, autrement ne le fay point."

Woudretton was detected and executed in 1384.

King John of England is supposed, according to the Records of the Tower of London,† to have poisoned Maud, the daughter of Earl Fitzwalter, whom he seized from her father's house, imprisoned in the Tower, and made illicit overtures to.

But poisoners are rare amongst English monarchs; this method of removing enemies was more common amongst foreign princes.

King Charles IX of France was even an experimenter in toxicology, for his cook having stolen two spoons was made to swallow a dose of corrosive sublimate, and afterwards given a substance named bezoar in order to see whether this was an antidote. The man, however, died in seven hours. And not 100 yards from where we are now sitting one Margaret Davie was in 1542 boiled alive in Smithfield for poisoning persons in three households with whom she had resided.

But the practice of poisoning reached its zenith in the fifteenth to the seventeenth century in Italy. Every one knows of the terrible use made of arsenic by the Pope Alexander VI, Lucrezia Borgia, and other members of the Borgia family. In the fifteenth century a school of poisoning existed at Venice, formally recognised by the State, and which made use of this criminal school for the purpose of removing princes, dukes, and other notabilities. Records still exist

of procedure and votings of the "Council of Ten," the reason for the crime, and the price to be paid to the poisoner.

In 1513 a Franciscan monk, John of Ragubo, submitted a number of poisons to this Council, offering to undertake the office of State poisoner. He was given a retaining fee of 1500 ducats yearly, to be increased if his services were satisfactory, and was deputed to perform first on the Emperor Maximilian. He drew up a tariff, which was accepted by the Council—viz. for the Sultan 500 ducats; King of Spain, 150 ducats; Pope, 100 ducats; Duke of Milan, 60 ducats; Marquis of Mantua, 50 ducats; travelling expenses to be allowed for all journeys. The performances of this Council seem only in a few cases to have been successful; but when this was the case there appears in the records the laconic marginal mark, "*factum*." Probably arsenic was the commonly used poison of the Venetian school.

In the sixteenth and seventeenth centuries an Italian school of poisoning was founded, and by that time further toxicological knowledge had been gained from published works, and notably that of J. Baptista Porta, appearing under the title of *Natural Neapolitan Magic*. In this work, in the chapters on "Cooking," he incidentally gives considerable information on the preparation of poisonous foods. He specially mentions belladonna, of which he recommends a port wine tincture, various Solanaceæ, and also nux vomica, aconite, and other poisonous plants. Another concoction of his was boluses or pills made of the powdered leaves of a species of aconite *Taxus baccata*, powdered glass, quicklime, sulphide of arsenic, and bitter almonds, all made up with honey.

Of the same period is the notorious Toffana, who is supposed to have poisoned at least three hundred persons with a preparation of arsenic which she called "*acquetta di Napoli*," or "*acqua Toffana*." Amongst her victims were two Popes—Pius XII and Clement XIV. This woman was tried at Rome in 1718, but managed to escape to a convent, where she continued to sell her drops for some twenty years longer. Another similar preparation of arsenic, known as "*acquetta di Perugia*," was also used at the same time. This woman Toffana had a number of disciples, who formed amongst themselves an association of young women poisoners.

This practice has by no means disappeared, records of husband poisoning on a large scale in Hungary so recently as last summer being obtainable. The trial has not yet begun of these prisoners.

In the seventeenth century we first begin to hear of corrosive sublimate as an important poison. Otto Tacken, of Westphalia, but usually living at Venice, gives details of the process of making this body, and refers to its poisonous properties.

Another Italian, named Exili or Eggidi, when imprisoned in Paris, taught M. de St. Croix, and he taught his paramour, Marguerite d'Aubray, Marquise de Brinvilliers, who poisoned her father, brothers, sisters, and many others. St. Croix himself died at the date of the death of Thérèse d'Aubray, according to public rumour as the result of a laboratory accident while making some poisons, probably AsH<sub>3</sub>. Brinvilliers escaped abroad, but was eventually captured by a ruse, which induced her to leave a convent in which she had taken refuge. After trial she was tied to a rack and submitted to the water torture (*i. e.* distended by compulsory swallowing of several gallons of water), and finally beheaded and burnt in 1676.

Despite this case, poisoning became so frequent in France that a special court (*chambre ardente*) was formed in 1680 to deal with cases of this kind.

A poisonous plant, *Spigelia anthelmia*, discovered about this time, was named Brinvillière, after the notorious poisoner.

A succession of French poisoners of this period—La Voisin, Vaneur, Saint Colombe, Bachimont, and others—trafficked not only in poisons, but also in abortives, aphrodisiacs, and other abominations.

Throughout this period eminent persons were in constant fear of being poisoned. Henry VII, according to the historians, adopted the most elaborate precautions to prevent the infant Prince of Wales from poisoning, and he in turn was in mortal terror of being poisoned by Anne Boleyn.

It must be borne in mind that at that time there was no science of toxicology, and it is doubtless in the main due to the growth of knowledge of means of detection that homicide by poisoning has so largely diminished. At the present time eminent persons hardly fear poisoning as a method of attack, and this is no doubt attributable to better diagnosis, if not to greater knowledge of treatment.

In these times poisoning—in which term I include accidental as well as suicidal and homicidal administration—varies considerably in character from one country to another, and changes also in one country from one period to another.

Thus in France and Germany carbonic oxide poisoning from char-

\* Hoefer, *Histoire de la chimie*.

† Hepworth Dixon, *Her Majesty's Tower*, 1869.



coal burners is very common; while in England, except in the form of poisoning by coal gas, it is extremely rare.

In France, from 1825 to 1880 the recorded cases of *criminal poisoning* amounted to 2123, of which arsenic and phosphorus were by far the most numerous.

	Cases.
Arsenic .....	823
Phosphorus .....	336
Copper salts .....	294
Sulphuric acid .....	67
Cantharides .....	59
Strychnine .....	28
Opium .....	21
Nitric acid .....	15
Mercury compounds .....	13
Hellebore, etc. ....	467
Total .....	2123

In England during the last ten years the number of recorded cases (including accidents and those arising from trade occupation) amounted to 6616, of which, however, only 42 were homicidal.

It is noteworthy that in this country opium and its preparations stand so much higher, and also carbolic acid and oxalic acid. This, no doubt, largely depends on the ease with which these bodies are purchased. Strychnine and phosphorus stand relatively high in the list, from the facile conditions of our Acts relating to patent preparations, and the occurrence of these in insect and other vermin killers.

	Cases.
Opiates .....	1379
Lead .....	1043
Carbolic .....	762 (490 suicides)
HCN, etc. ....	260 (222 " )
Oxalic .....	223
HCl .....	204
Strychnine .....	201 (150 " )
KCN .....	166 (122 " )
Vermin killer .....	127 (118 " )
Chloral .....	127
Arsenic .....	120
Chloroform .....	113
Alcohol .....	108
Ammonia .....	98
H <sub>2</sub> SO <sub>4</sub> .....	93
Belladonna .....	76 (20 suicidal)
Mercury preparations .....	60
Aconite .....	59 (19 " )

Total ..... 6616

Excluding poisoning by misadventure, we find that amongst suicides the order is as in the adjoining table, where arsenic is seen to lie low in the list.

Carbolic .....	290	Strychnine .....	150
Opiates .....	281	Vermin killer .....	118
HCN .....	222	Phosphorus .....	84
Oxalic .....	200	Arsenic .....	77

In Germany oxalic acid ranks low, as also does opium and carbolic acid, a table for three years for Berlin alone being—

Charcoal vapour .....	155	Oxalic acid .....	19
Corrosive acids .....	93	Arsenic .....	12
Phosphorus .....	41	Opium, etc. ....	12
KCN and HCN .....	38	Carbolic acid .....	2

It is also of interest to note—and important, as showing the effect of legislation—that in England up till 1880 carbolic acid was an unimportant body, while now, owing to the ease of obtaining it or its trade preparations, it is by far the most commonly used substance for suicidal poisoning.

Our toxicological knowledge necessarily is concurrent with the growth of chemistry. Boyle, in 1664 (*The Usefulness of Natural Philosophy*), makes shrewd observations on certain toxicological points.

Stahl, Marggraf, Brandt, Bergman, Berthollet, Priestley, and Lavoisier laid the foundations of toxicological chemistry. Thus Scheele discovered HCN, though he did not note its poisonous properties. He prepared oxalic acid from sorrel, and found that As unites with H, forming a foetid decomposable gas.

The first suggestion of the test now known as Marsh's test was by Proust in 1798, and the test was gradually improved by various chemists, and completed in 1836 by Marsh, who published a memoir on the subject.

Orfila, in Paris (1814-51), made an immense number of experiments, giving weighed doses to animals, and subsequently recovering the poisons from their tissues.

The discovery of alkaloids dates from about the beginning of this century, that of ptomaines and toxalbumins by Selmi.

My own experience in toxicology is necessarily somewhat limited in character. Cases of accidental poisoning, so frequently met with in injurious trade occupations—such as lead poisoning, mercurialisation, phosphorus necrosis,—rarely come under my notice, partly since they are rarely fatal, and are therefore met with and treated by the general practitioner, and partly because the cases in which a coroner's inquisition requires toxicological analysis are almost always those of suicide or homicide, or (unfortunately for the analyst) merely a groundless suspicion of such mode of death.

The recognition of most poisons, if inorganic, is usually straightforward enough, and in many cases the tests are so delicate that <sup>10000</sup> grain can with certainty be detected *after the poison has been separated*, though such a minute quantity as this cannot be recovered from the tissues.

A complaint which the analyst may very justly make is that he is often given no information as to the post-mortem appearances, the nature of the attack or illness preceding death, the character of the death, the position and aspect of the body. Certain coroners with whom I come into contact, and particularly those whose training is purely legal, are (apparently purposely) unwilling to supply this information to the analyst,—partly, perhaps, from the idea that he should determine the poison, if any, without prejudice, but which, if the coroner could only appreciate how much labour is frequently saved the analyst by such knowledge, he would, I feel sure, be less loth to supply. Quite three fifths of the London coroners I have to lodge this complaint against; and those who, on the other hand, willingly give this knowledge to me, or send me the depositions at the initial inquiry, are either those who have had medical training or who are more or less directly connected with the medical profession.

To give you an example: in poisoning by HCN the death is so typically sudden that the analyst may frequently conclude the nature of the poison, and a prompt distillation of the stomach contents may detect; but if there has been some delay in making the post-mortem or in sealing up the viscera or stomach contents, the opportunity for detecting this body is much reduced. Such delay, owing to red-tapism, usually occurs, and the detection of the poison rendered sometimes impossible.

In my own experience, out of 127 cases (in 45 of which there was no poison, and excluding also alcoholic coma) I have had more cases of ptomaine poisoning than of any other, and next most of oxalic acid and of cyanide.

I propose to draw the attention of this meeting to a number of points I have observed, to which no reference whatever is made in any of the text-books on the subject, or in which features observed differ essentially from those generally recorded.

KCN.—In poisoning by cyanide of potassium, if the dose swallowed has been large, a notable feature is the retardation of putrescence. In one case (D. S.—) I found 3·27 grains KCN in the stomach, and after the analysis was completed the stomach was put aside in a corked jar, and by inadvertence was not at once destroyed, but was left for three months in the chemical laboratory here, at the end of which time the viscera were found to show no sign of putrescence. This does not, however, occur if the dose is small. In these cases there is also much irritation of the mucous surface of the stomach, extravasation of blood, and erosion, probably from the action of the alkaline K<sub>2</sub>CO<sub>3</sub>, which exists so largely in commercial cyanide. Most of the text-books do not refer to this, but state that the appearances resemble those of prussic acid poisoning. Where the quantity of KCN is small it is hopeless to expect to detect it by smell, even after distillation: the fatty acids which distil over at the same time mask it completely, and the naked-eye test with AgNO<sub>3</sub> is liable in consequence to be very misleading. The microscopic recognition is better, and fortunately the Prussian blue reaction is very dependable even in minute doses.

In another case (C. G.—) six days elapsed between death and the commencement of the analysis, and I nearly failed to identify KCN in consequence. No smell, reaction with AgNO<sub>3</sub> uncertain, also that with Fe<sup>III</sup>(SCN)<sub>3</sub>; but Prussian blue test, under low microscope power, was most characteristic.

Another case was typical (J. H. C.—). He had been employed at

Maple's, and, being suspected of conspiracy, was discharged. Before leaving he ripped up and otherwise destroyed about £150 worth of furniture. On being arrested at his home he excused himself from the detectives and took poison in the water-closet, and was a few minutes later found *in extremis*. There could have hardly been any doubt of the poison. Here in this case no smell was detectable, and the stomach showed *white* patches in places, while the stomach contents were actually *acid* in reaction. This man was an amateur photographer, and had cyanide in use, besides several other poisons. The evidence was very precise as to times of the incidents preceding death, and it appears that he had taken the cyanide more than five and less than ten minutes preceding death.

*Oxalic.*—In the next most frequent of my own cases—viz. those of oxalic acid poisoning—the appearances are usually fairly characteristic. The death, if directly due to the drug, is usually rapid—ten to twenty minutes,—and the stomach contents are of an undecidable brown coffee-grounds-like appearance, probably mainly due to extravasated blood. This, together with excessive vomiting, frequently of blood, would alone be sufficient to indicate the poison; but fortunately there is nearly always a peculiar but highly characteristic bleaching and thickening of the mucous membrane of the œsophagus, mouth, and tongue, but rarely of the stomach. This poison is always readily detected.

Incidentally I should like to remark that it would be a distinct gain if in all cases of coroner's inquisitions the autopsy were made by a permanently appointed pathologist. I have had several cases of oxalic acid poisoning in which the post-mortem notes record absolutely nothing abnormal as to the appearance of the stomach surface and contents, though even when seen by me six or seven days after death the appearance is almost typical.

One of the saddest cases within my experience was that of a young lady (E. R—), where the quantity taken must have been very great, and the poison was readily found on veil, gloves, the fern-leaves round her mouth, on handkerchief, and, in fact, nearly every article of clothing.

This poison, in fact, is much too easily obtained, considering the absolutely fatal character of it and the little opportunity of giving an antidote. The poison can be obtained at any chemist's on the flimsiest pretext, and is, without doubt, very generally—though illegally—sold by oilmen and grocers, and should certainly be included in Schedule I of the Poisons Act. A dose of one to two drachms, despite the excessive vomiting, is almost certainly fatal, and it is little less dangerous than potassium cyanide.

It is, of course, often urged that it is impossible to legislate against suicide, and that if a person is balked of one method he or she will adopt another. To this argument I strongly demur. The temptation to commit suicide in many cases is proportional to the ease of execution; and the last case referred to, where depression after influenza was the cause, is one very much to the point.

In oxalic acid poisoning I have frequently observed arrest of putrefactive changes in the stomach and intestines, though the substance which produces this more than any other is, without doubt, arsenic.

It is singular that the popular idea should be so general that decomposition of the body is more rapid after death from poisoning than from natural causes.

*As.*—Many cases are on record of prolonged arrest of decomposition; one of arsenical poisoning mentioned in Taylor is of seven years' preservation of a corpse after burial.

One case is that of H. S—, in which death took place in eighteen hours. The stomach contained, despite sickness and that no food had been taken during illness, no less than 30 ounces of fluid, and these, when examined six days after death, were not in the least fetid. The quantity found was not large, and in consequence in the first examination it was overlooked, owing to its volatilising while the organic matter was being destroyed. There were patches of inflammation, but no white or yellow deposit, so often mentioned as occurring in these cases, and no petechiæ or punctiform hæmorrhages. I should conclude that a solution of arsenious oxide was swallowed, but the case was eminently unsatisfactory, as nothing was elucidated as to the way in which the *As* was obtained. There was a report that he had drunk ginger beer from a street barrow, but whether the death was one of misadventure or of suicide the evidence did not disclose. This is, in fact, one of the unsatisfactory features of toxicological work. It may be said that the duty of the analyst ceases with the determination of the poison, if any; but it is somewhat surprising the large proportion of cases in which the evidence is inconclusive, largely owing to reticence of relatives or other witnesses; and the police themselves do not assist in the investigation unless there is strong reason to suspect homicide.

Another instance (E. W—). Death occurred after three days, but

the *As* was readily recognised, although only one dose had been taken, and there had been continuous vomiting. In this case the poison was one sold publicly without questioning as rat poison, and consisted simply of grains of wheat slightly crushed, and with which  $As_2O_3$  was roughly mixed. The stomach surface showed nothing characteristic—only a slight general reddening. There was no diarrhœa.

*Opium.*—Of cases of poisoning by opium preparations I meet with less than normal of cases. This is probably due to the fact that the medical man who is called is usually able to testify to opium poisoning from evidence of bottles or of the deceased or relatives.

One of my earliest cases was that of an infant aged eighteen days (F. P—), whose death was attributed in the neighbourhood to be due to poisoning owing to a mistake by the medical man who made up the medicine, and who was accused of being drunk at the time. My own opinion is that the child died from bronchial catarrh and asphyxia, causing simulation of narcotic symptoms. I found no evidence of opium or morphine in the stomach, but the medicine, which I also examined, undoubtedly contained morphine in small amount. Here was a difficulty, as it involved the reputation of the medical man. I spent an unconscionable amount of pains over this analysis, but the conclusion was undoubted, and I had to leave it to be cleared up, if possible, later. It subsequently turned out that the parents took a bottle themselves to the dispensary for their child's medicine, which had previously contained a cough linctus, and that no one had thought of washing the bottle out.

*Strychnine.*—Strychnine poisoning is so characteristic that if the deceased is seen before death there is hardly any necessity for chemical analysis. A certain number of cases arise, however, in which the deceased is merely found dead, and seven such cases I have had under examination.

Apart from any helpful evidence of mode of death, the analyst's attention is directed to strychnine, sometimes by the presence of pigment—either lamp-black or Prussian blue. There are several vermin killers on the market in which strychnine is mixed with flour and pigment. The only analytical difficulty arises, then, from the stomach being full and the poison being more diluted. On account of the trouble of separating from other organic matter, and the tediousness of the operations, the colour reactions for this alkaloid are often hardly dependable, and the most reliable tests are microscopic ones, such as the formation of strychnine picrate, or crystals with  $KCNs$ , or  $K_2CrO_4$ , or  $K_3Fe(CN)_6$ , and the physiological test on the frog.

In most of these cases the strychnine was obtained in Battle's and other similar vermin killers, but in one suicidal case the deceased had swallowed a considerable number of nux vomica pills.

*Phosphorus.*—The cases of phosphorus poisoning are few, and invariably (in adults) are those of self-murder.

The recognition of this poison chemically is one of great difficulty, as the fatal termination is usually long delayed, death resulting from secondary causes. The shortest termination of a case I have had is one week, but in this case, despite the lapse of time, I was able to obtain evidence of phosphate, and especially of phosphite, which aided materially the determination. Not that there is often doubt; the pronounced fatty degeneration of all the organs is typical. I regret that in the cases I have had I have not been able to add specimens to the museum. Owing to the lapse of time between autopsy and chemical examination decomposition has in each case advanced too far for the specimen to be of any service in the museum. In no case has distillation of stomach contents been of any service; the time elapsed has resulted in complete oxidation of the phosphorus. Jaundice is not by any means a constant symptom, despite the extreme degeneration and infiltration of the liver which usually sets in about the second or third day after.

In one case the deceased was an in-patient of St. Thomas's Hospital for a week before death, but obstinately refused to give any information. The autopsy made the matter sufficiently clear, however, apart from chemical reactions.

*Carbolic.*—Cases of carbolic poisoning are very frequent, but their nature is so evident, and the appearances so characteristic, that they rarely come to the toxicological analyst. Apart from these, however, which present no special feature of interest, I have had at different times three cases of poisoning by Jeyes' fluid. It is only right to say that this preparation contains no carbolic acid, a fact of which the firm makes the very most in its advertisements, failing to mention, however, that the carbolic acid has been removed because of its intrinsic commercial value. Subsequent to the removal of the phenol the residue has added to it 20 per cent. by volume of commercial "cresol," containing, *i. e.*, higher substituted phenols, cresylic acid, etc., and which are stated to be non-poisonous. Although not poisonous in quite the same manner as phenol, this preparation from coal-tar,



which is extensively advertised as harmless, is, however, a very poisonous product. It produces, when swallowed, very much the same appearances—hyperæmia of the stomach and intestines, local capillary hæmorrhages, and contracted pupil. On each of these occasions I have drawn the attention of the solicitor of the company to this misrepresentation on its labels and wrappers, but have been unable to induce the firm to omit this mendacious statement of its harmlessness. On one occasion I was confronted with two chemists permanently on the staff of the company, and who swore that the preparation was innocuous, but they declined to test their statement by publicly swallowing a wine-glassful of the concoction. Here, again, is a case in which the law relating to the sale of poisonous chemicals requires reinforcing. It may be urged that a person would not drink so filthy-looking a liquid as Jeyes' disinfectant except for purposes of suicide; but, on the other hand, if the substance is described as harmless and non-poisonous, there is a tendency to leave bottles of it about, where it may come into the hands of children, or occasionally be swallowed by misadventure.

$\text{NH}_3$ .—I have had one case of death from swallowing Scrubb's cloudy ammonia. Here, fortunately for both the deceased and the analyst, the quantity swallowed was considerable, death being rapid, and the recognition of the substance was easy. The small intestine was almost black along its whole length from extravasated and altered blood. There was no recognisable smell of ammonia, this being masked by putrefaction, but there was unusual alkalinity, and the  $\text{NH}_3$  was readily obtained by distillation. The objection is frequently raised that  $\text{NH}_3$  can always be obtained by distillation of putrid tissues, but in this case the amount recovered was so considerable that putridity was out of the question as a cause. The medico-legal interest in the case lay in the evidence that the deceased complained of pain at the pit of the stomach; that *there was no vomiting*, but very persistent diarrhœa, one motion being passed in bed. Here, again, there was an attempt by the relatives to hide the cause of death; and, despite the serious illness, no medical man was called in until the patient was on the point of death, and no information was given of what the deceased had done. It was not until I found  $\text{NH}_3$  that a search of the house was made, that a bottle of Scrubb's ammonia was found, and that the information was elicited from the relatives that the deceased admitted that she had swallowed "something out of a bottle in the bath-room."

*Rue*.—One case I had was of attempted abortion by taking of infusion of rue and savin prepared by a woman herbalist. I have no doubt that in this case instrumental means were also adopted for procuring abortion, but the accused could not be convicted of this; nor should I have been able to make anything of the analysis but for the fortunate circumstance that a few leaves and vegetable *débris* were left in the infusion, which I was able to identify by comparison with others. The case was, however, singularly, also complicated by typhoidal or tubercular ulceration of the lower end of the small intestine and the existence of a perforation near the ileo-cæcal valve, with consequent suppurative peritonitis; and, despite the evidence of procuration of abortion, the accused woman was given the benefit of the doubt.

$\text{H}_2\text{SO}_4$ .—It has not been my fortune to see a case of  $\text{H}_2\text{SO}_4$  poisoning. During my student days here there was a case of very unusual character, where the deceased (who had frequently before attempted suicide) actually succeeded in swallowing half a pint of *oil of vitriol*. He lived for two hours, probably unconscious in the latter part; but it seems an anachronism that it was illegal to hasten the certain end. The acid destroyed nearly all the abdominal viscera, the liver being carbonised except for a piece in the middle about the size of a small apple, and worked its way through the thick dorsal muscles on to the slate slab in the post-mortem room.

*Ptomaines*.—The greater number of cases, and of which the proportion yearly increases, are those of ptomaine poisoning. I am very doubtful if this is a proper description; certainly the intense gastro-enteritis usually resulting cannot be caused by the small quantity of these basic substances actually swallowed, and the death is almost always due not to the toxic character of the ptomaines as to exhaustion consequent on persistent diarrhœa and vomiting and inability to retain food.

The recognition of these bodies is always a matter of extreme difficulty. In the present surroundings I have no hesitation in admitting that for these bodies and for the various toxalbumins there are no individually decisive chemical tests. In the main the reactions are merely the general ones of alkaloids, and it is only by detailed elimination of these in the first place that ptomaines can be definitely ascertained to be present. Brouardel describes a test depending on the reducing action of these bodies and formations of Prussian blue,

which he regards as distinctive; but this is not the case. Moreover the growth of bacteria, whether in the intestinal tract or under artificial conditions of culture, produces a number of nitrogenous products of disintegration of albumen, all of which possess reducing action.

Identification of ptomaines is almost impossible, as usually a number of these are formed simultaneously as disintegration products of albumen.

## Notes.

WE have been asked by the Committee of the R.A.M.C. South Africa Fund to collect a shilling subscription amongst our readers. The object of the fund is to send out to South Africa presents of suitable clothing and other comforts for the men of the Royal Army Medical Corps, now serving with the forces there. Articles in support of the fund have already appeared in the *Lancet* and the *British Medical Journal*. Sir Dyce Duckworth is a member of the Executive Committee of the Fund. Shilling subscriptions may be left with Mr. Madden in the Library, where a list will be found, or may be sent to the Editor of the JOURNAL. They will be acknowledged in the *Times*.

We have asked our Poet to help us in this appeal, and he has come to the rescue as follows:

### "THE DOCTOR" AT THE FRONT.

The strife still raged at its highest,  
Though kopje on kopje was won,  
And to many a gallant soldier  
The work of his life was done.  
'Mid the groans of the dead and the dying,  
'Mid the shriek of the shot and the shell  
Went the doctor; he's only a doctor,  
Unmoved by the anguish of hell.

With a cheery word to the wounded  
And a reverent hand to the dead,  
He closes the eyes of the latter,  
The former he lifts by the head.  
When the terror of death should appal him,  
His missions of mercy he fills;  
He's the doctor, only the doctor,  
Who looks to the poor Tommies' ills.

The soldiers who fight for their country  
Are honoured again and again;  
Officers, Tommies, and troopers—  
At least, that is, all that remain.  
But the man who has vied with the bravest,  
And done it—well, just for a whim,  
Is the doctor, only the doctor;  
What honour and credit for him?

If you speak to the average Tommy,  
And ask his opinion on this,  
He will think of the pains he has suffered,  
He will think of the bullet's dread hiss;  
And he'll say, "You don't know what we think, sir,  
You don't know the things we would do  
For the doctor, Gawd bless 'im, the doctor,  
'E's a good 'un, between me an' you."

C. v. L.

\* \* \*

LIEUT. H. K. PALMER, who is with No. 11 Field Hospital, accompanying General French's Cavalry Brigade at Rensburg, writes asking for such comforts as Magazines, Pipes, Tobacco, Cigarettes, and Warm Clothing, for his

Hospital. Mr. D. B. Keown, 88, Eaton Terrace, S.W., would gladly receive and forward any such articles.

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We omitted to state last month that we were indebted to the *British Medical Journal* for the photograph of Sir James Paget which we published. We take this opportunity of expressing our thanks for the opportunity afforded us of giving our readers such an excellent likeness.

\* \* \*

THE Milroy Lectures for 1900 will be delivered by Dr. F. J. Waldo, on March 8th, 13th, and 15th; subject: "Summer Diarrhoea, with special relation to Causation and Prevention." The Goulstonian Lectures will be delivered by Dr. P. Horton-Smith on March 20th, 22nd, and 27th; subject: "The Typhoid Bacillus and Typhoid Fever."

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MR. D'ARCY POWER has been appointed an Examiner in Surgery at the University of Durham.

\* \* \*

DR. SAMUEL WEST has been appointed Treasurer of the British Medical Benevolent Fund.

\* \* \*

MR. W. LANGDON BROWN has been appointed Casualty Physician, *vice* Mr. Jobson Horne.

\* \* \*

E. GANE, an old member of the Resident Staff, has been elected Honorary Visiting Physician to the Christchurch Hospital, New Zealand.

\* \* \*

G. V. WORTHINGTON has been appointed Surgeon to the Princess Christian Hospital, Cape Town.

\* \* \*

SURGEON SKEY, R.N., has been appointed to H.M.S. Excellent, Gunnery School, Portsmouth.

\* \* \*

H. S. THOMAS has been appointed Civil Medical Officer to the South African Field Force, 5A General Hospital, and sails on March 1st.

S. R. SCOTT has a similar appointment in connection with the 3rd Yorkshire Regiment, and is due to sail on February 28th.

\* \* \*

The following Bart.'s men have been admitted to the membership of the Royal College of Physicians: Messrs. W. LANGDON BROWN, CLIVE RIVIÈRE, R. JONES, and VINCENT.

\* \* \*

The thirty-fifth volume of the Hospital Reports, of which we publish a full review on another page, has many features to commend it. The punctuality of its appearance is not the least. We are glad to notice a tendency to introduce more illustrations, *not* produced, we sincerely

hope, at the expense of the contributors. The increase in the number of subscribers is but small, and the number still falls far short of 600. We could name at least three gentlemen who hold lectureships at St. Bartholomew's whose names do not appear on the list. Surely this defect only needs pointing out to them to be at once remedied.

\* \* \*

DR. ELIZABETH BLACKWELL writes to us as follows:

"No obituary notice of the distinguished member of St. Bartholomew's Hospital—Sir James Paget—would be complete without a record of the intelligent and large-hearted welcome which he gave to the entrance of women into the medical profession. This movement is now so well established in public favour, that it is difficult to recognise the distrust or hostility that had to be encountered by women, both in England and America, when the first attempts were made by them to obtain a regular and complete medical education.

"It was in 1850 that Mr. James Paget, then Warden of St. Bart.'s, with the cordial approval of the House Committee (of which Sir Sidney Waterlow was Chairman), admitted me to study at St. Bartholomew's Hospital. During my attendance at St. Bart.'s he welcomed me to his valuable lectures on Pathology given in the College; invited me to his house, where I was introduced to Professors Kölliker, Carpenter, and other distinguished scientific men, and gave every facility in his power for the acquisition of complete medical knowledge.

"In later years his professional advice and assistance were always cordially rendered to those lady physicians who desired to consult him.

"When I called on my old Professor in 1897 he welcomed me with his well-known cordiality; and his hearty parting words—'You are a credit to the Profession'—will always be gratefully remembered as a benediction on our work."

Dr. Elizabeth Blackwell was one of the pioneers in the movement of medical education among women. She graduated at Geneva and in the United States in 1849.

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THE *Daily Chronicle's* "Parliamentary representative" is more curious upon matters medical than it is wise for him to exhibit to the public. Speaking on February 9th of Mr. Gerald Balfour's illness, he said "he developed a few days ago two small thromboid growths in the veins of the leg, and on Wednesday one of these passed out through the lungs, the other passed to the heart, and had it been but a pin's head larger the worst consequences might have happened." Perhaps it was the same fruitful imagination we had to thank for that much better thing said in the columns of the same paper, when the breathing of a certain distinguished statesman during his last illness was described as having the "change-stroke" character.

*In Memoriam.*

## HARRY BOND.

**T**HERE could have been few people who were present at the Christmas Entertainment on January 5th who realised that it was the last appearance of Henry Bond at St. Bartholomew's Hospital.

On January 7th the news first arrived that he was seriously ill, and his friends heard through one of the senior physicians that he was in a dangerous condition. For the remainder of the week the war news was discarded, and the men discussed in the Square the various dangers of a double lobar pneumonia. However, at first hardly anyone doubted that a strong man like "Henry" would "pull through." Yet every morning they stood about waiting for news from Greenwich before starting any work, and each day the fears became greater, and although partly prepared, when his death occurred on Saturday, January 13th, it came as a great shock to every one at Bart's.

"Henry" was one of the most familiar and popular figures of late years at St. Bartholomew's Hospital. Coming to us direct from "Blundell's," he at once actively associated himself with the sports of the place, and during his career as a student did much to promote and improve many of the games. He represented the Hospital at Rugby and cricket, and eventually held the offices of Secretary and Captain of both teams. Under his leadership the cricket team secured the Inter-Hospital Cup for the first time. He also acted in 1897 as the energetic Secretary of the Amalgamated Clubs, and it was during this time that the ground at Winchmore Hill was opened. Doubtless the present excellence of that ground is due in part to his energy.

As Secretary to the "United Hospitals" he ably represented one of the greatest of those London institutions. He had a marvellous turn for all games, and enjoyed them thoroughly. Perhaps Rugby was his best. Every one who saw him playing back for the only London football club, as he used to call Blackheath, cannot fail to have admired the dash and the pluck, combined with steadiness of resource, which he always showed in that trying position.

He was always exceedingly popular with the crowd, and in this connection one recalls a match when, for some reason or another, he was figured on the card under an assumed name. This was some little time after he retired from Blackheath football. However, the crowd were not deceived. "That ain't no Buckingham," they said; "it's Harry Bond back again."

As a cricketer he was almost as good as he was at Rugby, and these were his two chief games. He was a very fine left-hand bat, and thought nothing of making his 100; in fact, he was one of those cheerful people who rather expected it. He was a member of the Incogniti, and was always rather proud of representing them.

Association was a game that he did not care very much about, and he only played on rare occasions. One remembers his going to the Crystal Palace when the Final of the English Cup was played there, and wandering round the ground trying to get a view of the game. After having been there some time and not having even seen the ball, he remarked to his companion, "Oh, never mind, old chap, it's only soccer." It was quite a typical remark, and showed one of his chief characteristics, that he was always cheerful, and seldom disturbed by anything.

With regard to his work, he was one of those very quick people with an absolutely clear mind. He was exceedingly observant, with plenty of common sense and

a keen sense of humour. He qualified in October, 1899, and soon afterwards took his first appointment as R.M.O. at Greenwich Infirmary. After being there for about a month he developed an attack of influenza; this he unfortunately neglected. It was followed by double pneumonia, which was responsible for his death.

As a student he gave up much of his time to games; had he lived, he would have shown that he could do his work with equal ability. When the news of his death arrived at Bart's it caused the deepest sorrow to all who knew him. It was difficult at first to conceive that the news was true.

His friends, both at Bart's and elsewhere, realise that they have lost one who was unswerving in his loyalty as a friend, and impossible to replace as a companion.—W.D.H.





### A Case of Poisoning by Cannabis Indica.

By EDWARD F. PALGRAVE, L.R.C.P.Lond., M.R.C.S.



HE toxic effects of cannabis indica are somewhat rare phenomena to witness, owing to the great caution usually exercised in exhibiting the drug, and therefore the following case seems to me worthy of narration.

The patient, a young man of about 25, fired apparently by some descriptions he had read of the fascinating mental symptoms incident on the taking of cannabis indica, had procured a supply of the drug wherewith to experiment. He sat down with a friend and together they made the following, it must be owned, patient and thorough investigation: first they each took 20m of the tincture; after an interval of half an hour another 20m each, and again a similar dose after a like period of waiting; in all 5j each in the space of an hour. After another latent period, during which nothing occurred, they each took 5ss; again disappointment and again 5ss, making a total of 5ij each. As the hour was now getting late they decided to take a final dose each and retire for the night, wherefore, nothing if not thorough in their measures, one took 5j as a dose and the other 5iss.

My patient had not long been in bed when the drug, beginning to assert itself, made it evident to him that he had overshot the mark, and that the pleasurable dreams he had anticipated were to be entirely subservient to most unpleasant sensations and impulses. He tells me that the first deviation from the normal was an extraordinary sense of exaggeration; the bed-clothes seemed heavy as if made of lead, and threatened to crush him; wishing to drink some water, he found the tumbler so weighty he could barely lift it, and a small "ruck" in a mat presented an obstacle of such height that he fell over it. As the minutes passed he became aware of a constant struggle between his normal will-power and the drug for the mastery. While the latter held the upper hand he was impelled to such acts as trying to get out of the window to see if he could fly; getting out a razor with a view to dissecting himself, and similar performances, all with a distinctly pre-judicial ending; in each instance he had just sufficient sense left to avert a catastrophe after a severe mental struggle, but recognising that his power of resistance was fast ebbing he utilised the next lucid interval to send for medical aid. The last thing he remembers clearly is that he was the Deity, floating along off the ground; he told me subsequently that he was much annoyed that any one should have the presumption to speak in his presence.

When seen he was in a state bordering upon mania; his face was flushed, his eyes were bright with widely dilated pupils, and he kept up a perpetual flow of more or less incoherent nonsense. Vision and hearing were extremely acute; he noticed everything and easily distinguished some whispered instructions given outside the room in which he was; his pulse was rapid and full. Every now and again he gave what was to the onlooker a slight start in one or other of his limbs; he himself said afterwards that he thought he had been severely convulsed. This idea was probably in part due to his exaggerated perceptions, and partly to the fact that he had been reading an account of the drug prior to taking it, and had been struck with the mention of the convulsant action of one of its active principles, titano cannabine; the remembrance of this doubtless

helped to intensify the notion he conceived as to the extent of his movements.

He was given a large dose of caffeine, which certainly appeared to act beneficially. In the midst of a most flowing and incoherent discourse on nothing in particular and everything in general, he sank back in his chair in a drowsy condition. The transition from delirious excitement to sudden stupor was so definite and well marked that I think, in relation to the caffeine, it may be asserted that it was "*propter*," not only "*post hoc*."

Being conveyed to bed, the patient slept soundly and awoke almost well the next morning, the only trace of his over-night escapade that was left being a slight disposition towards mental and bodily restlessness.

It is interesting to note that the only effect of the larger dose (5iiss) of the drug on the other investigator, who was, perhaps, of a more stolid and less imaginative temperament, was that of a pure hypnotic, and he passed a good night undisturbed by any untoward event.

### Amalgamated Clubs.

#### RUGBY FOOTBALL CLUB.

##### ST. BART.'S v. OLD MERCHANT TAYLORS.

Played at Richmond on December 9th, in bitterly cold weather, on a ground hardened by frost. The result—a win for O.M.Ts. by a try to *nil*—was most satisfactory, as O'Neill and Ash were not playing, and as it was generally expected that we should be beaten rather badly. Gillies arrived late, and we played short for the first ten minutes. The Hospital forwards were very ragged, and the Taylors gave us rather a bad time. The three-quarters and Stone, however, defended well, and the only score in the first half was a try by Buck after a quarter of an hour, which was not converted. On changing over, however, the forwards improved immensely, getting the ball time after time in the scrummages, and gaining a lot of ground by loose rushes. Both sides came near scoring, but the defence was always better than the attack, and so the game ended in the O.M.Ts. winning by a try (3 points) to *nil*. Adams was hurt in the last ten minutes,

and had to stop playing. Team:

St. Bart.'s.—E. S. Marshall (back); J. B. Gillies, C. Dix, G. W. James, H. W. Thompson (three-quarters); H. Howell, D. Stone (halves); H. C. Adams (captain), L. R. Tosswill, H. T. Wilson, A. R. Neligan, H. E. Graham, H. W. Thomson, W. H. Hamilton, E. C. Hodgson (forwards).

##### ST. BART.'S v. KENSINGTON.

Played at Wood Lane on January 13th. A series of disasters befell the team in this match. First of all Adams, O'Neill, Tosswill, Gillies, and Ash were unable to play; and as if this was not bad enough, three of the team took the wrong train, and did not turn up at all. It is said that they eventually reached Ealing! The remaining twelve, however, played their very hardest, and during the first half had actually more of the game than the full Kensington XV. Hamilton played half with Howell, and distinguished himself greatly. The five forwards worked like horses, and the backs—especially Price—kicked splendidly. Wilson once very nearly landed a penalty goal from near the touch-line. The only score was a penalty goal to our opponents—a very fine kick from nearly half-way.

After half-time numbers began to tell, and Kensington scored a try almost immediately. They continued to press, but it was not till towards the end that they ran in twice, and one try was converted. We were down in their "25" when the whistle blew. Kensington, therefore, won by 2 goals (1 penalty) and 2 tries (14 points) to *nil*. As it will be seen that only Wilson and Neligan of the regular forwards were playing, and that we had a forward at half, this result may be put down as very creditable. Team:

*St. Bart's.*—E. S. Marshall (back); H. W. Thompson, G. G. Ellett, E. W. Price, P. James (three-quarters); H. Howell, W. H. Hamilton (halves); H. T. Wilson (captain), A. R. Neligan, J. M. Plews, E. C. Hodgson, L. Arnould (forwards).

#### ST. BART'S v. STREATHAM.

Played at Streatham on Saturday, January 27th. The ground was in very bad condition owing to the recent rains, one corner being completely under water. The Bart's forwards were not nearly so well together as on the previous week at Portsmouth, some of the attempts at healing being very poor indeed. We were pressing nearly the whole of the first half, but the Streatham defence was very sure, and it was only just on the call of half-time that Ash scored between the posts from a pass by Stone. O'Neill converted. The first quarter of an hour of the second half was very even until from a good forward rush Harvey dribbled over the line and scored. O'Neill's kick was charged down. Before the end Ellett would have scored if he had not unfortunately been obliged to wade through water and mud, which considerably retarded his progress. The final score was—Bart's, 1 goal, 1 try (8 points); Streatham *nil*. Team:

*St. Bart's.*—E. S. Marshall (back); J. B. Gillies, G. G. Ellett, E. G. Drury, H. W. Thompson (three-quarters); B. N. Ash, D. M. Stone (halves); A. O'Neill, L. R. Tossill, H. T. Wilson, A. R. Neligan, J. M. Plews, F. Harvey, E. C. Hodgson, W. H. Scott (forwards).

#### INTER-HOSPITAL RUGBY UNION CHALLENGE CUP.

##### Second Round.

#### ST. BART'S v. GUY'S (Holders).

This match was played at Richmond on Tuesday, February 6th, before a crowd of over 1000. Bart's winning the toss elected to play with the wind. On starting, the Bart's forwards, who were heavier than Guy's, played up in good style, and fairly carried the scrummages into Guy's "25," but would not heel out quickly enough; in consequence of this, the three-quarters had very little chance. Once Gillies had a chance, but after a good run was pushed into touch. Two free kicks were given against Guy's halves for off-side play, but O'Neill failed to kick either goal.

On crossing over, Guy's certainly played a better game forward than did our men, and from a good heel out and a smart pass from Thomas, Lime scored far out. The kick was unsuccessful. We had the ball out more often in this half of the game, and Ash and Gillies made some good runs. Guy's forwards at one time rushed the ball into our "25," and our defence was sorely tried, but a good kick eventually cleared. Soon, however, a kick was charged down, and Guy's added a second try through Wall. The kick was again unsuccessful, and nothing further was scored. Thus ended a close and exciting game, in which O'Neill, Tossill, and Wilson, forward, and Ash at half, especially distinguished themselves; Guy's winning by 2 tries to *nil* (6-0). Teams:

*St. Bart's.*—E. S. Marshall (back); J. B. Gillies, G. G. Ellett, G. Drury, H. W. Thompson (three-quarters); B. N. Ash, F. R. Carroll (halves); H. C. Adams (capt.), A. O'Neill, L. R. Tossill, H. T. Wilson, A. R. Neligan, J. M. Plews, G. H. Adam, F. Harvey (forwards).

*Guy's.*—E. M. Harrison (back); F. W. Sime, C. D. Pye-Smith, F. D. S. Jackson, E. Morgan (three-quarters); M. G. Louison, S. Brown (halves); R. C. Mullins (capt.), D. H. Trail, T. P. Thomas, H. A. Cutler, P. T. Manson, K. V. Trutshaw, A. H. Wall, R. C. Lawrie (forwards).

*Referee.*—Mr. E. V. GARDNER.

IN the recent examination for the Navy, J. O'Hea obtained the fifth and P. Dyer the seventeenth place.

#### Abernethian Society.



ON January 25th a Clinical Evening was held, Mr. A. R. J. Douglas in the chair.

Mr. Morland was declared elected vice-president in the place of Mr. A. Granville.

Mr. Morland showed a case of mycosis fungoides, and made some explanatory remarks upon the case.

Mr. Douglas showed numerous pathological specimens, which excited much interest.

Numerous microscopical specimens were shown by members.

On February 1st, an ordinary meeting, the president, Mr. L. B. Rawling, being in the chair, Mr. J. H. Churchill read a paper on "Some Features of Blood Pathology." The speaker in the first part of the paper discussed the common features of pathological blood. He stated that he had made the high count of 10,080,000 red blood-corpuscles per c.mm. in a case of congenital heart disease, and compared it with the polycythæmia found in the altitudes where the oxygen pressure is much diminished; he alluded to the apparent increase in red blood-corpuscles due to the loss of plasma, *i.e.* in ascites, sweating, diarrhoea. He laid stress on the probability of chlorosis and pernicious anemia being ultimately classed as secondary anemias, instancing one case of a woman whose blood was in a condition of pernicious anemia, but in whom there was reason to believe the co-existence of malignant disease. He discussed the meaning of the large size of many of the red blood-corpuscles, their extreme variation in shape, and the presence of large nucleated reds which are features of pernicious anemia; contrasting the relation of hæmoglobin to the red corpuscle count, as expressed by the colour index in pernicious anemia and chlorosis, he pointed out the relative excess of hæmoglobin in pernicious anemia when the patient was losing ground, and its relative deficiency in chlorosis and secondary anemias, and thought that the colour index in chlorosis was a better guide to the condition of patient than corpuscle count, suggesting that rapidity in the loss of hæmoglobin was the important factor in the severity of the case.

Leucocytes, their characters and proportions in normal blood, and leucocytosis, were dealt fully with. The pathological causes were described at length.

A case was cited of a boy with a mediastinal tumour, whose blood acquired two or three weeks before death the condition of lymphatic leukæmia, and another case of an infant with a mixed leukæmia, who is about and well now; two younger members of the family having subsequently suffered from a disease apparently similar in all respects, except that they lacked the enormous number of leucocytes. He pointed out the position these cases occupied between leukæmia and other conditions, and concluded by drawing attention to two of the specimens shown, one of a lymphocyte dividing in the blood, and the other of a case of splenic leukæmia with 9 per cent. of basophile corpuscles.

A number of microscopical slides illustrating the various pathological conditions of the blood were exhibited.

An interesting discussion followed upon the paper.

On February 8th, an ordinary meeting, the president, Mr. A. R. J. Douglas, being in the chair, Dr. J. L. Maxwell read a paper on the "Comparative Values of the Vaginal and Abdominal Routes in the Operative Treatment of Pelvic Diseases." Dr. Maxwell spoke at length upon the great value of the vaginal route, and considered that in most cases it was the safest to employ. The cases upon which operative treatment was required he divided into three classes:

1. Those in which the vaginal route was the safest.
2. Those in which both routes had certain points in their favour.
3. Those in which the combined route was the best.

These classes he illustrated by the notes of cases which he read, showing that the vaginal route was, on the whole, the more satisfactory, the recovery of the patients being quicker, and, on the whole, more complete.

A lengthy discussion followed.

We hope to be able to print Dr. Maxwell's paper *in extenso* at an early date.

On February 15th, an ordinary meeting, the vice-president, Mr. Morland, being in the chair, Mr. L. B. Rawling read a paper on "Cancer of the Oesophagus." Mr. Rawling, in a most interesting paper, gave a lengthy *résumé* of the pathological conditions of the disease. From the notes of 110 cases which he had collected from the hospital records, he found that the earliest age at which it occurred was twenty-eight, and the latest seventy-four. From the notes

he pointed out the great difficulty often arising in the diagnosis, and condemned strongly the use of the œsophageal bougie. The cause and treatment of the disease were then fully discussed. The average duration of the disease was eight months, and secondary growths in the glands of the neck occurred in 80 per cent. of cases.

In the discussion which followed the question of treatment was freely gone into.

### The Rahere Lodge, No. 2546.



MEETING of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, on Tuesday evening, February 13th, 1900. W. Bro. R. J. Reece, M.D., the W.M. in the chair. Bro. James Calvert, M.D., of the Alliance Lodge, No. 1827, Warden of the College, St. Bartholomew's Hospital, was elected a Joining Member, and Bro. E. H. Thompson was passed to the second degree in Freemasonry. W. Bro. E. C. Cripps, P.P.G.D.C. Gloucester, delivered the second section of the second lecture in a most impressive manner. The brethren with their guests afterwards dined together.

### Reviews.

ST. BARTHOLOMEW'S HOSPITAL REPORTS, Vol. XXXV, edited by NORMAN MOORE, M.D., and D'ARCY POWER, F.R.C.S. (London: Smith, Elder, & Co., 1900.)

The thirty-fifth volume of the *Hospital Reports* has just appeared, under the editorship of Dr. Norman Moore and Mr. D'Arcy Power. At the outset we may remark that a very instructive portion of the book is the list of subscribers. We find the total number is 518—surely a most meagre and altogether inadequate figure! We would urge the claims of the *Reports* upon all the readers of the *JOURNAL*; the efforts of the Editors to make them worthily representative of our Hospital deserve much more generous support.

The earliest page—the frontispiece itself—reminds us of a recent and irreparable loss; for we have thereon an excellent portrait of the late Professor Kanthack. This is accompanied by a sympathetic appreciation, signed with the familiar initials A. A. B. There is also a brief obituary of Dr. Reginald Southey, who, although he resigned his appointments here in 1883, is still remembered among us.

Turning to the scientific articles, we find an interesting record of the cases of abdominal section performed during 1898 by Mr. Harrison Cripps in the Martha Theatre. During this period twenty-seven ovariectomies and seven hysterectomies were performed, all ending in recovery; and seventeen miscellaneous cases, with thirteen recoveries and four deaths. Of the four fatal cases, one was extensive malignant disease in the pelvis, one a pyosalpinx communicating with the rectum and complicated by a dermoid cyst of one ovary, and one was for ruptured uterus with profuse antecedent hæmorrhage. The remaining fatal case was a death from chloroform.

Mr. D'Arcy Power publishes an instructive article on the operations he performed during the sixteen months following his appointment as Assistant Surgeon, and the lessons to be deduced therefrom. The total number is 224, and includes twenty-four cases of abdominal section, which form an interesting series.

Mr. Rundle has a well-timed and sensible contribution on varicocele in relation to admission to the Services. He points out that varicocele exists in a large number of young people—probably 18 to 20 per cent.—and does not produce any physical discomfort, and that it ought not to be considered a cause for disqualifying them, except in rare and pronounced cases, from entering the Services. Ordinary cases do not demand operation; the pronounced cases, which do, only form about 1 per cent. of the total number. Yet at present the average number per cent. of candidates rejected for varicocele is 16.2. We wish we could think that Mr. Rundle's much-needed protest will produce the desired effect. In cases where operation is required he is strongly in favour of ligature and excision of veins by the "open" method.

Dr. Auden's article on arteritis in relation to enteric fever is an admirable account of what is known of this rare complication. The clinical cases, which came under his own observation, are full of interest.

Mr. C. S. Myers relates what he has seen of the conditions of life on a Torres Straits Island, and what he could glean of Malay midwifery. It is their custom to express the placenta, and not to employ traction, so that a few years ago they could have claimed a more scientific method than that which was in vogue in this country. We doubt, however, if their treatment for retained placenta will ever find much favour here, for in this case the mother goes out into the sea. It is not surprising to learn that a daughter of one of the present kings of the island died a few years ago under this treatment.

Dr. Herringham records an interesting case of Graves' disease in a man with extreme emaciation. Of the extremity of the emaciation the reader can judge from a series of photographs. Dr. Herringham leans to the view that the fundamental lesion in Graves' disease will be found in the parathyroids. But surely, knowing as we do the extraordinary influence of thyroid extract in the reduction of obesity, his case of extreme emaciation lends support to the "hypersecretion" theory. At least the suggestion is tempting.

Dr. Parkes Weber's article on congenital valvular defects on the left side of the heart will repay careful reading. He gives reasons for believing that such defects are much more common than is usually supposed. "One of the difficulties in recognising defects of the semilunar valves due to foetal endocarditis on the left side of the heart, is that the minor results of the foetal endocarditis may closely resemble the results of later endocarditis.



Moreover . . . rheumatic endocarditis occurring at any period after birth, when it affects aortic valves previously damaged by foetal endocarditis, may produce such alterations that at a subsequent post-mortem examination the changes caused by the foetal disease cannot be distinguished amongst those due to the latter disease. Sir James Paget was, I think, the first to call attention to the frequency of disease affecting the aortic and pulmonary orifices when there were congenitally only two instead of three semilunar valves. . . . In many cases of mitral stenosis in young persons no history of acute rheumatism can be obtained, and a congenital origin for the disease has been suggested."

Another article of decided interest is Dr. Horder's, on chronic Bright's disease as a cause of sudden death, with some remarks upon sudden death generally. To summarise his principal conclusions, it appears that this disease is a not infrequent cause of sudden death, apart from any associated condition known to lead to this result. In his collected cases it was responsible for 16.6 per cent. Further, chronic Bright's disease is an extremely frequent accompaniment of the various vascular cardiac and respiratory diseases found to produce sudden death; and this frequency is greater in these diseases when thus terminating, than when they lead to death which is not sudden—the frequency being 62.5 per cent. The variety of Bright's disease thus found is chronic interstitial nephritis. The age incidence in cases of sudden death shows two periods of life during which the condition mainly occurs—(i) from birth up to three years; (ii) from thirty years onwards. From three to fourteen there is practical immunity. There is a large excess of males over females among the adult cases (10 to 1), and a conspicuous excess of females over males in the case of children (5 to 3).

There are other articles worthy of notice, but our space is exhausted. A passing reference to the statistical tables prepared by the Medical and Surgical Registrars is imperative, however. The enormous labour entailed therein is too little recognised or taken too much for granted, and it is not out of place to express our gratitude for these careful records of our clinical storehouse.

A MANUAL OF SURGERY, for Students and Practitioners, by WM. ROSE, F.R.C.S., and ALBERT CARLESS, F.R.C.S. Second edition. (London: Messrs. Baillière, Tindall & Cox.) Demy 8vo; pp. 1190; price 21s. net.

A second edition of this manual within fourteen months of its original appearance bears testimony to its deserved popularity. The additions recently made to the older and, it must be confessed, somewhat unsatisfactory one-volume text-books have been both numerous and ambitious; but there seems no doubt that the work before us has given its rivals in the same field a keen struggle for existence.

The revision now made is thorough and well justified. There are some very helpful new diagrams added, particularly worthy of note being those reproduced from the College of Surgeons' pathological specimens; but the skiagraphs are also successful—a merit this form of illustration by no means always possesses in text-books,—and should prove of value to the student as helps in the interpretation of actual negatives. We notice a very liberal recommendation of the

antistreptococcus serum as a preliminary measure before certain operations, as in abdominal section, "if there seems a likelihood of streptococcal infection."

We can cordially repeat the recommendation of this manual which we gave it at the time of its first edition.

THE PATHOLOGIST'S HANDBOOK: a Manual for the Post-mortem Room, by T. N. KELYNACK, M.D., M.R.C.P. (London: Messrs. J. and A. Churchill.) Pp. 186; price 4s. 6d.

This handbook is the outcome of "many years' experience of teaching in the pathological department of the Manchester Royal Infirmary;" yet our verdict upon it, remembering Dr. Kelynack's contributions to pathology, and controlling any tendency to be hypercritical, is that we are utterly disappointed with the result. The very name is a misnomer, for the book deals solely with the manipulations of the deadhouse, and as a practical guide to the post-mortem room the book is totally inadequate. If it made up for its hopeless brevity of description by the virtue of its illustrations, of which it boasts a great wealth, we might pardon it; but it does not. Out of 126 figures, the first fifty are of instruments, the majority of which in post-mortem work are quite superfluous, if not worse. Thus we have such unnecessary things depicted as "scissors with angular blades," "Tiemann's double-bladed section knife," "trowel-shanked section knife," "long metacarpal saw," and a host of other weapons. And the implements that are necessary hardly need the amount of space allotted to their representation. The photographs of various morbid viscera are amateurish to a degree, useless in consequence, and but a waste of the pages containing them. Even the glitter of the fluid upon the surface of the objects photographed (a fault easily avoided by any but the beginner) has received no attention from the operator. As for the photographs intended to illustrate certain methods of post-mortem procedure, they are even worse still. In Fig. 83, showing "method of opening intestines," something might possibly be learnt if the intestine could be seen. The same remark applies to Fig. 87, showing (!) "method of opening bladder and urethra in position," where a director, which is quite undiscoverable, "indicates the necrotic bladder." And there are others as bad. We see by the preface that the photographs are by Mr. W. S. Kelynack. The name may be a coincidence merely, but if it is not, it is surely a pity to spoil what might possibly have been a successful enterprise by not going further afield for help.

MEDICAL GYMNASTICS: a Text-book of Massage and Mechanical Therapeutics generally, by AXEL V. GRAFSTROM, M.D., B.Sc. (London: The Scientific Press, Limited.) Price 2s. 6d.

This little book presents the subject of "mechanotherapy" in a concise form, so that it may be grasped in its essential details by the ordinary student. The book should prove specially useful to nurses, male and female, of whose equipment massage comes to be nowadays a not insignificant part. The descriptions of the various movements are lucid, and there are some good diagrams in the text. The author's English is curious in places. Thus, speaking of displaced kidney, he says, "Women suffer from it more than men, and virgins, nulliparæ, and multiparæ being alike its victims."

The book fills a long-felt want, and can be confidently recommended.

THE following paragraph appeared in the *Evening News* of February 21st:

#### LOGIC THAT FAILED.

In a case at the Shoreditch County Court the defendant, who was sued by a doctor for £9 4s., due for attendance on defendant's son, raised some curious points as a defence.

In the first place, he said the doctor, after attending the boy for some time, sent him to the hospital; ultimately the boy died. When told that the doctor did not guarantee a cure, and charged merely for the treatment he had given, defendant said the lad was treated for Bright's disease, whereas he was really suffering from dropsy. Could the doctor charge for wrong treatment and useless physics?

His Honour: No doctor can be certain of a complaint. He does the best for what he believes to be the trouble.

Judgment for plaintiff with costs.

## Correspondence.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

DEAR SIR,—Publicity is an arm whereby the greatest constitutions seek to remedy their defects, and I trust you will allow the following facts—at first sight unconnected—to appear in your columns.

(a) The library does not contain the collection of medical literature which the late Dr. Andrews bequeathed to the Hospital.

(b) The northern approach to the Anatomical Theatre is at present blocked with a heap of ponderous packing cases.

On inquiry I find these conditions to be mutually interdependent. Truly sings the poet:

"Full many a leaf of richest thoughts serene,  
The dark unhallowed haunts of Morris bare;  
Full many a page remains unread, unseen,  
And wastes its lesson 'neath the theatre stair."

Yours truly,

Tænia Bibliocephalus Latus

(Vulg.: The Bookworm).

*To the Editor of the St. Bartholomew's Hospital Journal.*

DEAR SIR,—Would you allow me to ask in your columns for copies of the JOURNAL for December, 1894, and January, 1895, as they are no longer obtainable from the manager?

Yours truly,

ALEX. R. TWEEDIE.

## New Addresses.

CLARK, W. GLADSTONE, from Surbiton, to 6, Nicholas Street, Chester.

COOKE, MARTIN A., from Badbrook House, to 19, Lansdown, Stroud, Gloucestershire.

FISHER, C., 5, Dicconson Terrace, Lytham.

GOWRING, B. W., from Victoria Place, to The Knoll, Stow Park Avenue, Newport, Mon.

HEMMING, J. J., 2, Grosvenor Villas, Margate.

HUGGINS, J. P., 3, Wallace Road, Canonbury.

KEOWN, D. B., from Ebury Street, to 88, Eaton Terrace, S.W.

MILES, W. E., from Ladbroke Grove, to 17, Devonshire Place, W.

ORMEROD, E. W., 87, Lansdowne Place, Hove.

PENNY, A. GERVASE, from 9, Queen's Avenue, to 40, Queen's Avenue, Muswell Hill, N.

POWELL, H. E., from Glencarn House, to 51, Upper Clapton Road, N.E.

POWELL, J. C., from Stoke-on-Trent, to 10, Victoria Terrace, St. Leonards-on-Sea.

ROLLESTON, H. D., from Harley Street, to 55, Upper Brook Street, W.

WYLLYS, W., 27, Nelson Road South, Great Yarmouth.

YOUNG, H. W. P., Eastleigh, Norbury, S.W.

## Appointments.

BAILEY, B. E. G., M.R.C.S., L.R.C.P., appointed House Physician to the Victoria Park Chest Hospital.

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COLEMAN, F., appointed House Surgeon to the Dental Hospital, Leicester Square, W.

GANE, E., has been elected Honorary Visiting Physician to the Christchurch Hospital, New Zealand.

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GOODMAN, H., M.R.C.S., L.R.C.P., appointed House Surgeon to the Beckett Hospital, Barnsley.

\* \* \*

HORNE, J. A., M.R.C.S., L.R.C.P., appointed Ship's Surgeon to the Cunard ss. Ultonia.

\* \* \*

ILLIUS, J. W., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Southampton Infirmary.

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ST. STEPHENS, W. T., M.R.C.S., L.R.C.P., Ship's Surgeon to the Royal Mail ss. Servia.

\* \* \*

THOMAS, H. S., M.R.C.S., L.R.C.P., appointed Civil Medical Officer to the South African Field Force.

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WORTHINGTON, G. V., B.A., M.B., B.C., appointed Surgeon to the Princess Christian Hospital, Cape Town.

## Examinations.

UNIVERSITY OF LONDON.

*Preliminary Scientific Examination.*

*Chemistry and Physics.*—Moss, B. E., Powell, N. B., Trist, J. R. R. *Biology.*—Gooding, F.

*Intermediate Examination in Medicine.*

*Entire Examination: Second Division.*—Pringle, E. G., Wenham, H. V.

*Excluding Physiology: First Division.*—Williams, E. C. *Second Division.*—Low, G. H., Smith, E. B., Waugh, R. J.

CONJOINT BOARD.

The following have completed the examinations for the Diplomas of M.R.C.S., L.R.C.P.:—Izard, A. W., Inchley, O., Peters, C. A., Grace, N., Pinker, H. G., Nixon, J. A., Truman, B. R. B., Gillespie, T., Branson, W. P. S., Cornish, C. V., Collins, J. M., Nunn, J. W., Valerie, J., Illius, J. W., Pennefather, C. M., Gomez, G.

## Birth.

WILLIS.—On February 2nd, at Fairlawn, Bromley Common, the wife of Cyril H. Willis, M.R.C.S., L.R.C.P.Lond., of a daughter (Rhoda Thring), who survived her birth two hours.

## Marriage.

BROCK—FLEMING.—On February 7th, at St. George's Presbyterian Church, Southport, by the Rev. J. Mellis, John Brock, Assistant Medical Officer, Uganda Railway, B.S.A., youngest son of the late Mr. Jas. Brock, of Bishopsteignton, Devon, to Ethel, youngest daughter of the late Rev. R. D. Fleming, of Coleraine, co. Antrim.

ACKNOWLEDGMENTS.—*M.R.J., London Hospital Gazette, St. Mary's Hospital Gazette, The Nursing Record, The Stethoscope, St. Thomas's Hospital Gazette, Guy's Hospital Gazette, Charing Cross Hospital Gazette, Middlesex Hospital Gazette, The Broadway, St. George's Hospital Gazette, The Polyclinic, The Medical Review (formerly The Medical and Surgical Review of Reviews), The Practitioner, University College Magazine, The Student, The Hospital, Le Mois Médico-Chirurgical, Bollettino della Associazione Sanataria Milanese.*